Human Infection with Middle East Respiratory Syndrome (MERS)
Case-Patient Investigation Form

State/Local ID:	CDC ID:	HH ID:	Cluster ID:	Dash Sticker:

COVER SHEET

Case-Patient Contact Information

Date of interview: MM / DD / YYYY

Last Name: _____ First Name: _____

Home Street Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Country: _____

Phone number: _____ Email address: _____

Other Phone number: _____

Other Points of Contact

1. Last Name: _____ First Name: _____
   Phone number: _____ Email address: _____
   Relationship to Case-Patient _____

2. Last Name: _____ First Name: _____
   Phone number: _____ Email address: _____
   Relationship to Case-Patient _____

3. Last Name: _____ First Name: _____
   Phone number: _____ Email address: _____
   Relationship to Case-Patient _____

4. Last Name: _____ First Name: _____
   Phone number: _____ Email address: _____
   Relationship to Case-Patient _____

State/Local ID:	CDC ID:	HH ID:	Cluster ID:	Dash Sticker:

BLANK

State/Local ID:	CDC ID:	HH ID:	Cluster ID:	Dash Sticker:

CASE-PATIENT INVESTIGATION FORM

I. Interview Information

Date of interview: MM / DD / YYYY

Interviewer:

Interviewer Name (Last, First): _____

State/Local Health Department: _____

Business Address: _____

City: _____ State: _____ County: _____

Phone number: _____ Email address: _____

Case-patient:

Who is providing information for this form?

- ☐ Case-patient
- ☐ Other, specify person (Last, First): _____
  Relationship to case-patient: _____

Reason case-patient unable to provide information: ☐ Case-patient is a minor ☐ Other _____

Case-patient primary language: _____

Was this form administered via a translator? ☐ Yes ☐ No

II. Case-Patient Information

At the time of this report, is the case-patient? ☐ Confirmed ☐ Probable

At the time of this report, what is the case-patient's status? ☐ Hospitalized ☐ Recovered ☐ Died ☐ Other _____

Date case-patient reported to public health officials: MM / DD / YYYY

Notes:

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III. Case-Patient Demographics

Date of birth: MM / DD / YYYY **Age (specify months or years):** ☐ _____Months ☐ _____Years

Sex: ☐ Male ☐ Female

Current Residence: City _____ County _____ State _____ Country _____

Residence At Time Of Illness: ☐ Same as current address

Street Address _____City _____ State _____
County _____ Country _____

Living situation at time of illness:

☐ Private residence ☐ Military base ☐ Shelter ☐ Nursing home/long-term healthcare facility

☐ School dormitory ☐ Homeless ☐ Other:_____

Race

☐ White ☐ Middle Eastern
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Multiracial
☐ Not Specified

Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Not specified

U.S. Resident

☐ Yes
☐ No

Nationality (If Not U.S)

_____

State/Local ID: CDC ID:

IV. Case-Patient Medical History

1. Does/did the patient have any of the following pre-existing medical conditions?

Medical condition	Currently	Ever	Unk	Comments
Chronic metabolic disease				
Diabetes ☐Type 1 ☐Type 2	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Chronic lung disease				
Emphysema/COPD	☐Y ☐N	☐Y ☐N	☐	
Tracheostomy	☐Y ☐N	☐Y ☐N	☐	
Asthma/reactive airway disease	☐Y ☐N	☐Y ☐N	☐	
Use of supplemental oxygen at home	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Blood disorders				
Sickle Cell Disease	☐Y ☐N	☐Y ☐N	☐	
Splenectomy/asplenia	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Immunocompromising conditions				
HIV ☐AIDS/CD4 count<200	☐Y ☐N	☐Y ☐N	☐	
Stem cell transplant	☐Y ☐N	☐Y ☐N	☐	
Organ transplant (specify)	☐Y ☐N	☐Y ☐N	☐	
Cancer in last 12 months (specify)	☐Y ☐N	☐Y ☐N	☐	
Chemotherapy in last 12 months	☐Y ☐N	☐Y ☐N	☐	
Primary immune deficiency (specify)	☐Y ☐N	☐Y ☐N	☐	
Steroid therapy (specify type and duration)	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	

Renal disease				
Chronic disease/insufficiency	☐Y ☐N	☐Y ☐N	☐	
End stage disease	☐Y ☐N	☐Y ☐N	☐	
Dialysis	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Cardiovascular disease				
Hypertension	☐Y ☐N	☐Y ☐N	☐	
Coronary artery disease	☐Y ☐N	☐Y ☐N	☐	
Heart failure/CHF	☐Y ☐N	☐Y ☐N	☐	
Cerebrovascular accident/stroke	☐Y ☐N	☐Y ☐N	☐	
Congenital heart disease	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Neuromuscular/neurologic disorder				
Dementia	☐Y ☐N	☐Y ☐N	☐	
Severe developmental delay	☐Y ☐N	☐Y ☐N	☐	
Plegias/paralysis	☐Y ☐N	☐Y ☐N	☐	
Epilepsy/seizure disorder	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Other conditions				
Liver disease	☐Y ☐N	☐Y ☐N	☐	
Morbidly obese, or BMI≥40	☐Y ☐N	☐Y ☐N	☐	
Pregnancy (gestational age at Illness onset _____)	☐Y ☐N	☐Y ☐N	☐	
Post-partum (≤6 weeks)	☐Y ☐N	☐Y ☐N	☐	
Prematurity (for case-patients <1 year of age) gestational age____	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	
Other (specify)	☐Y ☐N	☐Y ☐N	☐	

State/Local ID: CDC ID:

V. Social History

Has the patient ever smoked cigarettes? ☐ Yes ☐ No ☐ Unknown

If yes: How many packs of cigarettes per day? _____ For how many years? _____

Does the patient currently smoke cigarettes? ☐ Yes ☐ No ☐ Unknown

How often does the patient have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times per week ☐ 4 or more times per week

VI. Illness History

Date of first symptom onset: MM / DD / YYYY

Please identify all symptoms since illness onset date but prior to hospitalization

Symptom	Symptom present?	Date of onset (MM/DD/YY)	Duration (no. of days)
Fever >38°C or 100.4°F	☐Y ☐N		
Chills	☐Y ☐N		
New onset cough or worsening of chronic cough	☐Y ☐N		
Dry	☐Y ☐N		
Productive (with sputum)	☐Y ☐N		
Bloody sputum/hemoptysis	☐Y ☐N		
Sore throat	☐Y ☐N		
Wheezing	☐Y ☐N		
Rhinorrhea (runny nose)	☐Y ☐N		
Ear pain	☐Y ☐N		
Chest pain	☐Y ☐N		
Apnea	☐Y ☐N		
Shortness of breath/dyspnea	☐Y ☐N		
Headache	☐Y ☐N		
Fatigue/weakness	☐Y ☐N		
Muscle aches (myalgia)	☐Y ☐N		

Joint pain (arthralgia)	☐Y ☐N		
Altered mental status	☐Y ☐N		
Dizziness	☐Y ☐N		
Seizures	☐Y ☐N		
Excessive crying (children aged <5 years)	☐Y ☐N		
Lethargy	☐Y ☐N		
Abdominal pain	☐Y ☐N		
Vomiting/nausea	☐Y ☐N		
Diarrhea (>3 loose stools/day)	☐Y ☐N		
Decreased appetite	☐Y ☐N		
Poor feeding (children aged <5 years)	☐Y ☐N		
Conjunctivitis (red eyes)	☐Y ☐N		
Skin rash (location:_____)	☐Y ☐N		
Skin ulcer (location:_____)	☐Y ☐N		
Lymphadenopathy	☐Y ☐N		
Bleeding (location:_____)	☐Y ☐N		
Change in urination (e.g., frequency, color)	☐Y ☐N		
Other:	☐Y ☐N		
Other:	☐Y ☐N		
Other:	☐Y ☐N		

Notes:

State/Local ID:

CDC ID:

State/Local ID: CDC ID:

VII. Medical Summary

Since illness onset, did the case-patient take any medications for MERS-related symptoms? (Include over the counter medications) ☐ Yes ☐ No ☐ Unknown

If yes, list:

Treatment/Medication	Route	Dose & Frequency	Start date (MM/DDYYYY)	Stop date (MM/DD/YYYY)

List any additional medications the case-patient is currently taking (e.g. prednisone or other steroid medications (excluding inhaled steroids), or immunosuppressant medications).

☐ No other medications

Treatment/Medication	Route	Dose & Frequency	Start date (MM/DDYYYY)	Stop date (MM/DD/YYYY)

State/Local ID: CDC ID:

Where has the case-patient sought medical care since illness onset?
(e.g., Primary Doctor, Outpatient Clinic, Emergency Department, etc.)

Date (MM/DD/YYYY)	**Name/Type of Facility**	**Name/Type Provider** (MD, RN, PA, Other)	**Notes/Description/Outcome**

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Was the case-patient admitted to a hospital? ☐ Yes ☐ No ☐ Unknown

If yes, please fill out Hospital Chart Abstraction form and list:

Date Admitted (MM/DD/YY)	Date Discharged (MM/DD/YY)	Name of Facility

State/Local ID:

CDC ID:

NOTES:

State/Local ID: CDC ID:

VIII. Travel History

In the 14 days prior to illness, did the patient travel:
outside of his/her city/town of current residence? ☐Yes ☐No ☐Unknown
outside of the country? ☐Yes ☐No ☐Unknown
If yes, specify travel details:

Place traveled	Date of departure MM/ DD/YYYY	Date of return MM/ DD/YYYY
Notes (transport method and provider, lodging,):		
Place travelled	Date of departure MM/ DD/YYYY	Date of return MM/ DD/YYYY
Notes (transport method and provider, lodging,):		
Place traveled	Date of departure MM/ DD/YYYY	Date of return MM/ DD/YYYY
Notes (transport method and provider, lodging,):		

Notes:

State/Local ID: CDC ID:

IX. Exposure Settings

Occupation and Job Duties:
(If student, indicate grade level)

Place of Work/School/University/DayCare:

Location #1: ☐Work ☐School/University ☐DayCare ☐Other: _____

Location Name: _____

Address: _____ City: _____ County: _____ State: _____

Phone: _____

Employment or School/University/Daycare Attendance: ☐Full Time ☐Part-time

Days worked or attended/week:_____ Hours/day: _____ Hours/week: _____

Days missed due to illness: _____

Transportation to/from: (check all that apply)

☐Private Car ☐Carpool ☐Public Bus ☐School Bus ☐Train/Subway ☐Other: _____

Location #2: ☐Work ☐School/University ☐DayCare ☐Other: _____

Location Name: _____

Address: _____ City: _____ County: _____ State: _____

Phone: _____

Employment or School/University/Daycare Attendance: ☐Full Time ☐Part-time

Days worked or attended/week:_____ Hours/day: _____ Hours/week: _____

Days missed due to illness: _____

Transportation to/from: (check all that apply)

☐Private Car ☐Carpool ☐Public Bus ☐School Bus ☐Train/Subway ☐Other: _____

Notes:

State/Local ID: CDC ID:

X. Exposure History

****For any "yes" answers to the following questions, please make sure that they are reflected in the fourteen–day activity history prior to illness section. Please list each contact on the corresponding tables (XIII, XIV, or XV) and on the contact tracing table XVI.**

Is there knowledge of any household members, friends, acquaintances, or co-workers who had symptoms like the case-patient's within 14 days before or during the patient's illness?

☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness**, did the case-patient have **close contact** with a **lab-confirmed or probable MERS case-patient?**

☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness**, did the case-patient have **close contact** with **an ill person who had contact with a lab-confirmed MERS case-patient**? ☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness**, did the case-patient have **close contact** with a person who had **a fever with acute respiratory illness, and recent travel in or near the Arabian Peninsula?** ☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness**, did the case-patient have **close contact** with a **person who recently travelled in or near the Arabian Peninsula**? ☐Yes ☐No ☐Unknown
If yes, what country/countries? _____

In the **14 DAYS prior to illness**, did the case-patient **attend any events where a lot of people were present** (religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?

☐Yes ☐No ☐Unknown

In the 14 **days prior to illness onset,** did the case-patient have **contact with any animals including household pets?**

☐Yes ☐No ☐Unknown
If yes, please list animal type and specify location of contact :

In the **14 DAYS prior to illness onset, anyone in the household (other than the case-patient) attend school or daycare?** ☐Yes ☐No ☐Unknown ☐N/A
If yes, provide name and location:

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In the **14 DAYS prior to illness,** did the case-patient **work in a healthcare setting?** ☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness,** did the case-patient **volunteer in a healthcare setting?** ☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness,** did the case-patient **visit a healthcare setting?** ☐Yes ☐No ☐Unknown

If yes to any above, specify location, type of facility (nursing home, hospital, outpatient clinic, etc.):

If yes to any above, did the case-patient have direct contact with other patients? ☐Yes ☐No ☐Unknown

In the **14 DAYS prior to illness,** did the case-patient **work in a laboratory setting handling blood, blood products, tissues or samples, or viral or bacterial samples?**

☐Yes ☐No ☐Unknown

If yes, specify location and materials:

Notes:

State/Local ID: CDC ID:

XI. FOURTEEN-DAY ACTIVITY HISTORY PRIOR TO ILLNESS			
Please list all activities you participated in the fourteen days prior to illness onset			
	AM Events/Locations	**PM Events/Locations**	**Notes**
Date of illness onset: MM / DD / YYYY			
1 day before illness onset MM / DD / YYYY			
2 days before illness onset MM / DD / YYYY			
3 days before illness onset MM / DD / YYYY			
4 days before illness onset MM / DD / YYYY			
5 days before illness onset MM / DD / YYYY			
6 days before illness onset MM / DD / YYYY			
7 days before illness onset MM / DD / YYYY			

8 days before illness onset MM / DD / YYYY			
9 days before illness onset MM / DD / YYYY			
10 days before illness onset MM / DD / YYYY			
11 days before illness onset MM / DD / YYYY			
12 days before illness onset MM / DD / YYYY			
13 days before illness onset MM / DD / YYYY			
14 days before illness onset MM / DD / YYYY			

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XII. ACTIVITY HISTORY AFTER ILLNESS ONSET			
Please list all activities you participated in during the period of illness (FROM: MM / DD / YYYY THROUGH: 14 days after illness onset or today's date (if less than 14 days since illness onset): MM / DD / YYYY. If you are a student, please include your class schedule (class name and location).			
	AM Events/Locations	**PM Events/Locations**	**Notes**
Date of illness onset: MM / DD / YYYY			
1 day after illness onset MM / DD / YYYY			
2 days after illness onset MM / DD / YYYY			
3 days after illness onset MM / DD / YYYY			
4 days after illness onset MM / DD / YYYY			
5 days after illness onset MM / DD / YYYY			
6 days after illness onset MM / DD / YYYY			
7 days after illness onset MM / DD / YYYY			

State/Local ID: CDC ID:

8 days after illness onset MM / DD / YYYY			
9 days after illness onset MM / DD / YYYY			
10 days after illness onset MM / DD / YYYY			
11 days after illness onset MM / DD / YYYY			
12 days after illness onset MM / DD / YYYY			
13 days after illness onset MM / DD / YYYY			
14 days after illness onset MM / DD / YYYY			

State/Local ID: CDC ID:

XIII. Household Contacts

Period of exposure:

From: 14 days before date of illness onset in case-patient: MM/ DD/YYYY

Through: 14 days after illness onset in case-patient OR today's date (if less than 14 days since illness onset): MM/ DD/YYYY

A household contact is anyone who stayed overnight for at least one night in a household with the same case-patient during the defined period of exposure.

How many people in total resided in the household during this period including the case-patient?____people. (please list below):

Name	Relationship to case-patient	Sex (M/F)	Age	Date of last exposure (MM/DD/YYYY)	Respiratory illness during period of exposure to case-patient	Date of Illness onset (MM/DD/YYYY)
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	
					☐Yes ☐No ☐Unknown	

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XIV. Close Contacts

Period of Exposure

From: 14 days before date of illness onset in case-patient: MM/ DD/YYYY

Through: 14 days after illness onset in case-patient OR today's date (if less than 14 days since illness onset): MM/ DD/YYYY

Did the case-patient have close contact (e.g. physical contact, sharing confined airspace) with anyone other than their household members during this period? ☐Yes (Please list below) ☐No (go to next question) ☐Unknown

Setting	Name	Relationship to case-patient	Sex (M/F)	Age	Date of last exposure (MM/DD/YYYY)	Respiratory illness during period of exposure	Date of Illness onset (MM/DD/YYYY)
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	
						☐Yes ☐No ☐Unknown	

State/Local ID: CDC ID:

XV. Casual Contacts

Period of Exposure

From: 14 days before date of illness onset in case-patient: MM/ DD/YYYY

Through: 14 days after illness onset in case-patient OR today's date (if less than 14 days since illness onset): MM/ DD/YYYY

Does the case-patient know any casual contacts that had fever and acute respiratory illness (e.g., cough, sore throat, pneumonia) beginning AFTER the case-patient's illness onset? ☐Yes (Please list below) ☐No ☐Unknown

Name	Relationship to case-patient	Sex (M/F)	Age	Date of illness onset	Symptom(s)

Notes:

State/Local ID: CDC ID:

XVI. Contact Information for all Household, Close and Casual Contacts		
Name	**Age**	**Contact Information**
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:

State/Local ID:

CDC ID:

Name	Age	Contact Information
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:

State/Local ID:

CDC ID:

Name	Age	Contact Information
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:
		Address: Phone: Email:

State/Local ID: CDC ID:

XVII. Final Case-Patient Outcome

☐ Survived

☐ Died

☐ Unknown

Appendix A

Case Definitions

Patient Under Investigation (PUI)

A patient under investigation (PUI) is a person with the following characteristics:

- fever (≥38°C, 100.4°F) and pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence);

AND EITHER

- history of travel from countries in or near the Arabian Peninsula[1] within 14 days before symptom onset;

OR

- close contact[2] with a symptomatic traveler who developed fever and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula;[1]

OR

- is a member of a cluster of patients with severe acute respiratory illness (e.g. fever and pneumonia requiring hospitalization) of unknown etiology in which MERS-CoV is being evaluated, in consultation with state and local health departments.

Confirmed Case

A confirmed case is a person with laboratory confirmation[3] of MERS-CoV infection.

Probable Case

A probable case is a PUI with absent or inconclusive[4] laboratory results for MERS-CoV infection who is a close contact[2] of a laboratory-confirmed MERS-CoV case.

Footnotes:

1. Countries considered in or near the Arabian Peninsula: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.
2. Close contact is defined as a) any person who provided care for the patient, including a healthcare worker or family member, or had similarly close physical contact; or b) any person who stayed at the same place (e.g. lived with, visited) as the patient while the patient was ill.
3. Confirmatory laboratory testing requires a positive PCR on at least two specific genomic targets or a single positive target with sequencing on a second.
4. Examples of laboratory results that may be considered inconclusive include a positive test on a single PCR target, a positive test with an assay that has limited performance data available, or a negative test on an inadequate specimen.

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ADDITIONAL NOTES OR COMMENTS: